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CORPORATION

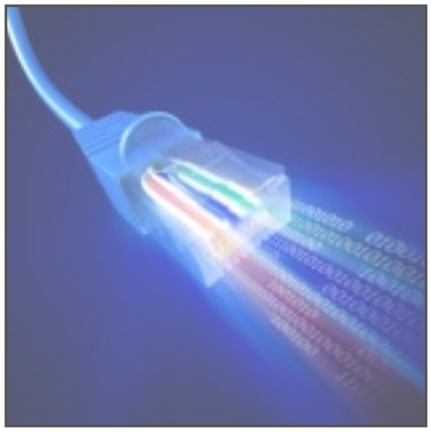
LESSONS LEARNED FROM DIAL UP

This article first appeared in the Los Angeles Daily Journal on May 15, 2014. In the largest cities across the United States, locating an Internet connection has become as easy as finding a cup of coffee. In modern times, however, the ability to effectively communicate in business is inextricably connected to the rate by which one is able to transfer data. Like a bad cup of coffee, we may tolerate a slow online connection when options are limited, but no one really enjoys it. Lessons from both support the notion that we not only prefer quality speed, but it also improves our performance at work.

If bit rates are the standard measurement for telecommunications, hospital beds present the equivalent in health care. When forestalling death or permanent injury, most health care practitioners prefer a hospital bed if options in venue exist. Like a hot spot at any local coffee shop, however, not all hospital beds are the same. While national standards for accreditation and certification exist to protect the public from health care delivered at a standard comparable to dial-up Internet access, the simple fact is that some hospital beds are better than others, and getting patients to the best possible bed is the first order of business.

Modern American health care has reached an epic crossroads on its path to reform, and at this juncture we as a nation should consider whether we would prefer a system that centers on a standard hospital bed in a nearby locale, or one that relies on an infrastructure that focuses on transporting the patient from any corner in the United States to an institution of excellence. Unfortunately, our nation's health care system is evolving at such a rate that if we delay this decision much longer, we may find out that the roads are closed in both directions.

In 1946 the United States Congress passed the Hill-Burton Act, legislation focused on bringing much needed care to a community 141 million strong. Since the passage of Medicare in 1965 the United States has seen a dearth of similar institutional movements. Instead, Congress and the Executive Branch have employed varying degrees of reform designed to address and repair the broken machinery found within our nation's health care structure. Perhaps the recent changes to the foundations of our health care system brought about by the Affordable Care Act make this the proper time for our nation to take a different approach.



According to estimates by the American Hospital Association, the United States offers approximately 920,829 hospital beds to provide for nearly 318 million inhabitants. Further data from the American Hospital Association suggests that our health care system is still 1,431,000 beds shy of meeting the burden of Hill-Burton (averaging approximately 2.89 beds per 1,000 people today). To make matters worse, the recent closing of hospitals in Sonoma County, California and Hayward County, Tennessee may have added even more distance to the 1946 goal. Still, these towns are certain to be more concerned over the recent loss of local beds than the meeting of a half-century old federal quota.

The increase in hospital closings nationwide is nothing short of an epidemic, but it remains unclear if we have successfully identified the underlying disease. There is no rainbow in the distance to mark economic optimism for community hospitals, as evidenced by last week's release of the 2015 federal regulations for inpatient hospital reimbursement under the Medicare program. Rather than deploy precious resources in an attempt to save those health care institutions sputtering on the brink of insolvency, we should consider a focus on national efforts to create an infrastructure that links key hospitals to remote communities that are unable to sustain facilities of their own.

The future of health care in the United States may no longer depend upon saving small community hospitals, although their closures will always remain tragic to the communities they serve. On the other hand, creating an infrastructure that would help the citizens of Brownville cover the 64 miles to Methodist Hospitals of Memphis, Tennessee faster and safer may in time be a viable option that would offset the obvious risks to the town's inhabitants. Even so, such a solution would come at a price, and the creation of a dynamic hospital infrastructure would require patience and flexibility in its initial stages. This is the cost of progress in today's health care climate.

To be sure, it is little more than a nuisance to abandon the home dial up Internet connection and head to the office and its 500 megabits per second download speed on a Sunday afternoon. On the other hand, a transformation of our health care infrastructure into a system that functions at the levels demanded by modern society from its institutions of medicine would be truly epic.

THE LIGHT AT THE END OF THE TUNNEL . . . OR CLIFF

"Truth emerges more readily from error than from confusion." — Francis Bacon

This article first appeared in Corporate Compliance Insights on June 2, 2014. With each passing day health care reform in America gains momentum, even as the chasm between successful and unsuccessful providers continues to expand. Earlier this month, the Federal Government tested the fortitude of the system when it released thousands of regulatory pages explaining the many ways in which Medicare providers will get paid and penalized over the next few years. Not to disappoint its devoted readers, the Powers That Be issued regulations the same week for skilled nursing facilities, inpatient psychiatric facilities, inpatient rehabilitation facilities, hospices, and federally qualified health centers.

In the midst of the resulting chaos, one promulgation exists as both a beacon of hope and shrine to disbelief in the tumultuous sea of obfuscation that has arisen under the myriad regulations governing modern health care reform. Originally issued January 18, 2011, Executive Order 13563 stated that each of the federal agencies "identify and consider regulatory approaches that reduce burdens and maintain flexibility" as well as eliminate rules "that may be outmoded, ineffective, insufficient, or excessively burdensome." Once again, the Federal Government is apparently attempting to save the day and welcome the return of any Medicare philistine.

Here are some highlights:

Extended Long Term Care Sprinkler Deadlines

Those long term care (LTC) facilities still operating without an automatic sprinkler that have been out of compliance since August 13, 2013 can breathe a sigh of relief, as the new regulations afford up to a three-year extension, subject to certain conditions. Originally included in a 2008 provision, the Centers for Medicare & Medicaid Services (CMS) articulated that fire safety in nursing homes must be protected by an automatic sprinkler system no later than August 2013. Even as long-term facilities rush to make a claim for this elusive two-year (and possibly even three-year) extension, CMS will continue to cite those institutions who remain out of compliance. The financial impact of this extension is an estimated one-time savings of $22 million.

Rethinking Hospital Leadership

After reflecting upon an influx of public commentary, CMS reversed itself on a 2012 rule that allowed for a single governing body to oversee multiple hospitals in a multi-hospital system, provided that at least one medical staff member from each hospital holds a position thereon "as a means of ensuring communication and coordination between the governing body and the medical staffs of individual hospitals in the system."

Recognizing the potential conflict created by the 2012 regulation, especially for public and not-for-profit hospitals, the new regulation eliminates a need for the governing body from a multi-hospital system to include a member from each hospital's medical staff provided there exists a mechanism to force communication between the system leadership and the individual charged with overseeing each of the different medical staffs. This includes, in part, "discussions," the frequency of which is left to the discretion of the hospital systems.

As the discussion over medical staff involvement in hospital governance rages on, CMS has also recognized a need to clarify which health care practitioners qualify for inclusion on a medical staff. In a previous regulation the Federal Government expanded the list to include doctors of dental surgery, dental medicine, podiatrists, optometrists, clinical psychologists and chiropractors. Now, it has clarified that advanced practice registered nurses, physician assistants, registered dietitians and doctors of pharmacy can also join the ranks of a hospital's medical staff, provided their involvement does not conflict with applicable state law.

Dietitians Get Their Day

In California, Registered Dietitians (RDs) must undergo formal education in the field of dietetics, among other disciplines, and train for no less than 900 hours before passing an examination. A false representation that one has satisfied this criteria may amount to a misdemeanor. Previously, states interpreted past regulations as placing the burden of monitoring the effectiveness of dietary plans on the physician only.

Recent regulations view the RD as "an integral member of the hospital interdisciplinary care team" and "responsible for a patient's nutritional diagnosis and treatment" in light of a patient's medical diagnosis."

One point of contention with the new regulation focuses on the potential "monopoly" this created for the RD industry. In response to these concerns, the new regulations clarify that the terms "qualified dietitian" and "RD" are not "exclusive of other nutrition professionals qualified to practice in the hospital setting." True to the intent of Executive Order 13563, CMS has suggested flexibility, not to mention compliance with state law, before making a final determination.

The Perpetual Balance Between Performance and Preservation

"Confusion is a word we have invented for an order which is not understood." — Henry Miller

This article first appeared in Volume XXX, Issue 2 of the *Journal of Contemporary Health Law and Policy.*

Passed by Congress and signed by President Lyndon Johnson into law in 1965, Medicare has weathered storms from all directions, growing to be the preeminent standard for health insurance in the United States. The idea of losing Medicare as a vital public benefit still remains the single greatest fear with which each passing generation of Americans must contend, and yet, these challenges over the past 50 years, designed to fortify Medicare's foundation and ensure its longevity, continue to take a toll on the program.

The most recent climate of reform includes changes implemented by the Patient Protection and Affordable Care Act ("PPACA"). Designed to expand coverage for a broader group of people, these changes add unprecedented layers of complexity such that it may be but a matter of time before the confusion experienced by today's providers proves to be Medicare's undoing altogether. The decades of trial and error upon which health care in the United States have been built, at least from the point of view of both physicians and lawmakers who watch from the sidelines, may give way to confusion and disruption industry-wide as a result of newly enacted regulations.

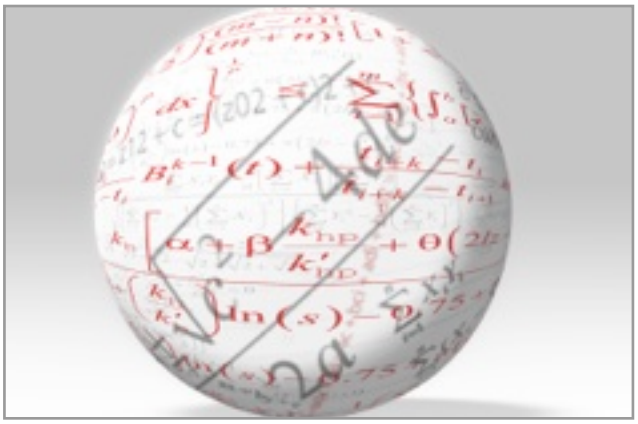
Today, Medicare is the preeminent standard for health insurance in the United States, expanding despite the fluctuations in the economic, political and social climate since its initial passage. However, in its struggle toward sustainability, the Medicare Program must understand the resulting consequences as it distances itself further and further from its original simplicity of 1965.

Medicare's original cost-based system gave way in the 1980's to the Prospective Payment System ("PPS"), an event noted by many with great concern. Under PPACA the Medicare system takes another monumental step as it incorporates elements of performance into the PPS. Formulaic and confusing, Medicare's recent approach to provider reimbursement has been likened to *Finnegan's Wake* by James Joyce, a book that some critics warn requires "skeleton keys" to understand. In many ways, the need for hospitals and physicians to comprehend these performance-based measures may seem less important when fear of Medicare insolvency looms in the distance. Irrespective of the fleeting grasp providers may have over PPACA's new Medicare system, hospitals and physicians alike are mindful that the PPS as they once knew it is gone, replaced in part with the beginnings of a performance-based Medicare in which they may lose precious revenue, one percentage point at a time.

Perhaps the most significant change occurred in the 1980s under the Reagan administration with the introduction of the PPS and diagnosis-related groups ("DRGs"). Restructuring the Medicare system by reimbursing hospitals "at a fixed amount for each patient discharged regardless of the costs incurred by the hospital," DRGs to this day remain at the center of the Medicare system.

Over time, however, DRGs have evolved to such an extent that their current level of complexity may be seen as counterintuitive to their original intent. By 2008, DRGs splintered into Medicare Severity Diagnosis Related Groups ("MS-DRGs"), thereby transforming the relatively simple 1982 system of 467 DRGs into a modern day labyrinth.

In its attempt to provide a more solid groundwork for American healthcare, PPACA did what may have been previously considered impossible by making Medicare reimbursements even more complicated, escalating the process to a level where the system of guaranteed health insurance can only be explained through algorithms. Some of the more intricate topics include the Hospital Value Based Purchasing Program ("VBP"), Hospital Readmissions Reduction Program ("RRP"), Hospital-Acquired Conditions ("HAC") and Healthcare-Associated Infections ("HAI"), as well as a total reconfiguration of Medicare disproportionate share ("DSH") payments. These regulations will test the resolve of any Medicare enthusiast, especially those without an advanced degree in mathematics.



If successful, this redistribution of Medicare funding among hospitals is only the beginning of what may soon become a total reconfiguration of the Medicare program. From its humble origins in 1965, when it cost beneficiaries $3.00 per year for coverage under Part B, Medicare has grown to become anything but modest when viewed in terms of its ever-evolving infrastructure. Only time will tell if modern healthcare's recently added complexities will fortify America's healthcare structure or create a series of financial cracks to weaken the foundations upon which it was built.

The complete article can be seen at www.garnerhealth.com or jchlp.law.edu.